

**DEPARTMENT OF VETERANS' AFFAIRS
APPLICATION FOR ADMISSION
TO THE ILLINOIS VETERANS' HOMES**

Quincy Veterans' Home
1707 North 12th Street
Quincy, IL 62301

Manteno Veterans' Home
One Veterans Drive
Manteno, IL 60950

LaSalle Veterans' Home
1015 O'Connor Avenue
LaSalle, IL 61301

Anna Veterans' Home
792 North Main Street
Anna, IL 62906

(217) 222-8641, Ext. 209

(815) 468-6581, Ext. 226

(815) 223-0303, Ext. 210

(618) 833-6302, Ext. 123

READ INSTRUCTIONS BEFORE COMPLETING APPLICATION:

Print in black ink or type. Answer all questions. Assistance in completing this application can be obtained from any Department of Veterans' Affairs Field Service Office. The information that you provide as part of this application will be used to determine the eligibility and appropriate level of care and to do preliminary planning for care and treatment. The financial section is needed to determine the appropriate charges based on the charge statement. This application can only be signed by the applicant or their legal representative.

SOC. SEC #: _____

APPLICANT'S FULL NAME: _____
(FIRST) (MIDDLE) (LAST)

MAILING ADDRESS: _____ COUNTY: _____

CITY: _____ STATE: _____ ZIP CODE: _____ PH. # () _____

SERVICE #: _____ V.A. CLAIM #: C- _____ RELIGION: _____

TYPE OF DISCHARGE: _____ WERE YOU A P.O.W.? _____ YES _____ NO

BRANCH OF MILITARY SERVICE: _____ ARMY _____ NAVY _____ MARINE _____ AIR FORCE _____
_____ COAST GUARD _____ MERCHANT MARINE

SERVED DURING: _____ WORLD WAR I _____ WORLD WAR II _____ KOREAN _____ VIETNAM _____ OTHER

DATE ENTERED ACTIVE SERVICE: _____ PLACE ENLISTED: _____

DATE OF DISCHARGE: _____ PLACE DISCHARGED: _____

RANK AT DISCHARGE: _____ UNIT NO. AND NAME: _____

OTHER SIGNIFICANT MILITARY INFORMATION: _____

DATE OF BIRTH: _____ BIRTHPLACE: _____ AGE: _____ SEX _____

MARITAL STATUS: _____ MARRIED _____ WIDOWED _____ DIVORCED _____ SEPARATED _____ SINGLE

NUMBER OF DEPENDENTS: _____ FORMER OCCUPATION OF VETERAN: _____

HAVE YOU PREVIOUSLY RESIDED AT OR APPLIED FOR MEMBERSHIP AT THIS HOME OR ANOTHER ILLINOIS VETERANS' HOME?

_____ YES _____ NO IF YES, WHICH HOME? _____

ARE YOU PRESENTLY ON A WAITING LIST AT ANOTHER ILLINOIS VETERANS' HOME?

_____ YES _____ NO IF YES, WHICH HOME? _____

I (HAVE / HAVE NOT) LIVED IN THE STATE OF ILLINOIS CONTINUOUSLY FOR THE PAST ONE YEAR.

RESIDENCE FOR LAST ONE YEAR: _____ FROM: _____ TO: _____

SOCIAL INFORMATION

LIST ALL INFORMATION ON SPOUSE (INCLUDE MAIDEN NAME IF FEMALE) AND ALL CHILDREN BORN OF THIS UNION. LIST CHILDREN BORN OF PREVIOUS MARRIAGE(S). USE ADDITIONAL SHEET IF NECESSARY.

	<u>FULL NAME</u>	<u>RELATIONSHIP</u>	<u>BIRTH DATE</u>	<u>ADDRESS</u>
1.	_____			
2.	_____			
3.	_____			
4.	_____			
5.	_____			

PLEASE LIST PERSONS TO NOTIFY IN CASE OF EMERGENCY, OR IF ADDITIONAL INFORMATION IS NEEDED.

#1 PERSON	_____	RELATIONSHIP:	_____
ADDRESS	_____	PHONE #:	_____
CITY	_____	STATE: _____	ZIP: _____
WORK #:	_____		
#2 PERSON	_____	RELATIONSHIP:	_____
ADDRESS	_____	PHONE #:	_____
CITY	_____	STATE: _____	ZIP: _____
WORK #:	_____		
#3 PERSON	_____	RELATIONSHIP:	_____
ADDRESS	_____	PHONE #:	_____
CITY	_____	STATE: _____	ZIP: _____
WORK #:	_____		

(PLEASE LIST ANY ADDITIONAL PERSONS ON A SEPARATE SHEET.)

FINANCIAL INFORMATION

The applicant is charged a Monthly Maintenance Charge to live at an Illinois Veterans' Home. The following financial information is needed for both the veteran and spouse to properly advise an applicant and spouse about V.A. Benefits.

	Name of Bank or Savings & Loan	Amount	Type of Account	Location
1.	_____	\$ _____	_____	_____
2.	_____	\$ _____	_____	_____
3.	_____	\$ _____	_____	_____
4.	_____	\$ _____	_____	_____
5.	_____	\$ _____	_____	_____

MONTHLY INCOME AMOUNTS

	VETERAN MONTHLY AMOUNT	SPOUSE MONTHLY AMOUNT
VETERAN'S PENSION OR COMPENSATION (SERVICE CONNECTED WHAT %? _____)	\$ _____	\$ _____
SOCIAL SECURITY	\$ _____	\$ _____
MONTHLY INTEREST / DIVIDENDS	\$ _____	\$ _____
PENSION BENEFITS	\$ _____	\$ _____
ANNUITY	\$ _____	\$ _____
RENTAL PROPERTY (NET)	\$ _____	\$ _____
OTHER	\$ _____	\$ _____
TOTAL MONTHLY INCOME	\$ _____	\$ _____

IF ABOVE INCOME GOES TO A REPRESENTATIVE PAYEE, PLEASE PROVIDE THEIR NAME, ADDRESS, AND PHONE #:

INSURANCE POLICIES

HEALTH INSURANCE (NON-MEDICARE) YES _____ NO _____ MONTHLY PREMIUM COST: _____

COMPANY: _____ POLICY NO: _____

PLEASE PROVIDE A COPY OF INSURANCE CARD (FRONT AND BACK)

MEDICARE: PART A (HOSPITALIZATION) YES _____ NO _____ EFFECTIVE DATE _____

MEDICARE: PART B (MEDICAL COVERAGE) YES _____ NO _____ EFFECTIVE DATE _____

ADVANCE DIRECTIVES AND LEGAL AUTHORITY

DO YOU HAVE ANY OF THE FOLLOWING ADVANCE DIRECTIVES OR LEGAL APPOINTMENTS:

LIVING WILL _____ YES _____ NO _____ CONSERVATOR _____ YES _____ NO _____

LEGAL GUARDIANSHIP _____ YES _____ NO _____

POWER OF ATTORNEY _____ YES _____ NO _____ WHAT TYPE _____

NOTE: IF YOU ANSWERED **YES** TO ANY OF THE ABOVE QUESTIONS REGARDING ADVANCE DIRECTIVES OR LEGAL AUTHORITY YOU **MUST** PROVIDE A COPY OF THOSE DOCUMENTS BEFORE OR UPON ADMISSION.

I agree to abide by and obey the rules and regulations governing the Illinois Veterans' Homes and to accept transfer to another hospital, special treatment center, or Home if in the opinion of the Medical Staff, such transfer is deemed advisable. I/We understand that should I/We receive additional income or be eligible for any additional income at any future date, from any sources, that it is mandatory that it be reported to the Home, and that failure to do so shall be cause for discharge.

This authorizes the Administrator of the Home or his/her representative to verify any facts relative to my/our financial status or income.

I have read or have had read to me all questions and answers on this form and the answers are true and complete to the best of my knowledge and belief. I also understand that any falsification regarding the aforementioned information will be reason for discharge from the Home.

SIGNED: _____

DATE: _____

IMPORTANT NOTICE: This application must be fully completed in all portions and accompanied by a Photostatic copy of your HONORABLE DISCHARGE (DD 214), and the DEPARTMENT OF VETERANS' AFFAIRS HEALTH QUESTIONNAIRE. If this form is signed by anyone other than the applicant, a copy of their legal authority must accompany the application.

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TO BE COMPLETED BY DEPARTMENT PERSONNEL

Applicant (meets) (does not meet) Veterans' eligibility criteria.

Signature of Adjutant

Applicant medically (eligible) (ineligible)

Signature of Medical Officer

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This application has been carefully investigated and it is recommended that the Applicant (be admitted) (not be admitted) to reside in the Illinois Veterans' Home.

This State Agency is requesting disclosure of information necessary to accomplish the statutory purpose of P.A. 79-1384, Paragraph 5. Inasmuch as this information is VOLUNTARY, failure to provide same may prevent admission to the Veterans' Home.

DATE

SIGNATURE OF ADMINSTRATOR